Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Insurance Enrollment and Change Form (FORM -1)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	/

Name - Last | First | MI

Address ☐ This is a new address | City | State | Zip Code

Date Entered Service	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #:	Home Phone	Work Phone
/ /			( )	( )

02 ☐ **BASIC LIFE, HEALTH AND LTD COVERAGE** **Effective Date: / 01 /**

New Enrollment ☐ Change ☐ **CANCEL COVERAGE** ☐ Long Term Disability (LTD) ☐ Health Insurance ☐ Optional Life Insurance

☐ **Basic Life Only**
☐ **Long Term Disability (LTD)**
☐ **Basic Life and Health** (Select one of the Health Plans below)

Annual Salary: $ _____

Salary Effective Date: _____ /_____ /_____

Health Plan

☐ **Commonwealth Indemnity Plan** CIC: ☐ Yes ☐ No
☐ **Commonwealth Indemnity Plan PLUS** ☐ **Harvard Pilgrim POS** ☐ **Navigator by Tufts Health Plan** ☐ **Individual**
☐ **Commonwealth Indemnity Community Choice** ☐ **HMO:** _____ ☐ **Family**
(write in the name of the HMO)

Optional Life **Please Check One:**

☐ **Automatic Increase**
Indicate Multiple Factor (1-8): _____
Multiple Factor 2-8 times is allowed only with Automatic increase.
Changing from Non Automatic to Automatic requires a medical form.

☐ **Non Automatic Increase**
Amount $: _____
No more than $1000 less than annual salary rounded down to the nearest $ 1,000

Please Check One:

☐ **Smoker**

☐ **Non-Smoker**
Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates

03 ☐ **Name Change** | Previous Name | New Name

LEAVE OF ABSENCE

FOR GIC USE ONLY: **Effective Date: / 01 /**

Leave Pay Status: ☐ Part ☐ Full

04 ☐ **Leave Is:** ☐ With Pay ☐ Without Pay

Leave Type (You MUST Check one of the following):

____ Educational ____ Family (for dep > age 3) *____ Maternity *____ Personal Illness ____ Sabbatical ____ FMLA
____ Family (for dep < age 3) *____ Industrial Accident ____ Military ____ Personal Reason ____ Suspension ____ Other

* Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date / / End Date / / Last Day on Payroll / /

05 ☐ **Return to Payroll Deduction:** First Day Back on Payroll / /

INSURED CHANGES

FOR GIC USE ONLY: **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / /

07 ☐ **Transfer to another Agency** Name of Agency Transferred to Effective Date / /

08 ☐ **Transfer from another Agency** Previous Agency Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason _____ Termination Date _____ /_____ /_____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

SIGNATURE REQUIRED

Long Term Disability Insurance (LTD)
I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability.

Optional Life Insurance
I understand that by not applying to be insured for the maximum amount of Optional Life Insurance available to me when first eligible, I may not increase my Optional Life insurance until I have waited at least one year from the original effective date and satisfactorily pass a medical examination.

Deduction Authorization
I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

At Retirement
I hereby certify that I have filed, or intend to file, an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans.

Termination
I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in HPHC POS or an HMO, be sure to file an application with the Plan.

x _____ Signature of Authorized Official Date

x _____ Signature of Authorized Applicant Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR **RETIREES:** RETURN COMPLETED FORM TO THE GIC